



Welcome to this edition of *Hospital Happenings*, a newsletter published by the North Dakota Department of Health, Division of Health Facilities. *Hospital Happenings* is designed to help hospitals and critical access hospitals stay up-to-date on various issues. Please share with your staff.

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## HOSPITAL REVIEWS

By Bridget Weidner

Peer review.  
Utilization review.  
Review of medical records as part of a periodic evaluation.  
I am sure there are more types of review we could discuss. No wonder there can be some confusion! This article will discuss the differences and the purposes behind these reviews.

### PEER REVIEW

Peer review is a system or process by which a physician or a committee of physicians investigates the medical care rendered by other physicians in order to assess the quality of health care delivered and to determine whether accepted standards of care have been met.

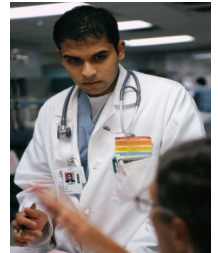
Whether a general acute hospital or a critical access hospital (CAH), federal regulations require each hospital to have a quality assurance/assessment program. The federal CAH regulations state: "The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and the treatment outcomes." The federal general acute hospital regulations state: "The hospital must develop, implement, and maintain an effective, ongoing hospital-wide, data-driven quality assessment and performance improvement program ... and focuses on indicators related to improved health outcomes ... The hospital must measure, analyze, and track quality indicators...and other aspects of performance that assess processes of

care, hospital services and operations."

The regulations require that all patient care services and others affecting patient health and safety are evaluated. This includes reviewing the services provided by the physician(s). To review the quality of services provided by the physician(s), surveyors review the hospital's process for peer review. The term peer review is not used in the regulations but it is addressed through the requirement for quality assurance/assessment.

Peer review is meant to provide independent medical opinions conducted by an objective group of physicians and relevant medical staff. Review should occur by another individual who has comparable levels of training, credentials, and experience. An individual physician cannot conduct a peer review of his or her own cases nor can a non-peer perform the peer review. In this case, look at a network provider, QIO, or neighboring community. It is not meant to be a performance appraisal but instead a part of the hospital's quality assurance/assessment program.

Each hospital needs to establish criteria to identify areas that would require a peer review. If the established criterion is not met, the record needs to be reviewed by a



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qualified reviewer. The process for peer review should be addressed in the medical staff bylaws. The process for peer review that is approved in the bylaws needs to be followed. There should be a facility policy with criteria and developed forms. If no record is flagged for peer review based on established criteria, the expectation is to conduct a peer review for quality of treatment. The policy should address the follow-up steps to take after the peer review. The peer review process should be ongoing.

Examples of acceptable criteria that the Department of Health has seen used include:

- ◇ Unplanned return to ER within 48 hours.
- ◇ ER patient not seen by MD.
- ◇ Complaint.
- ◇ Death (unexpected).
- ◇ Hospital stay more than 96 hours.
- ◇ Against medical advice (AMA).
- ◇ Adverse reaction.
- ◇ Surgical wound complication.
- ◇ Unimproved case or complications requiring transfer or resulting in extended stay.
- ◇ Hospital-acquired infection or injury.
- ◇ Emergency obstetrical care, if service not provided.
- ◇ Obstetrical cases with complications to mother or baby if services offered.
- ◇ Unstable emergency room cases transferred to another hospital.
- ◇ Cases identified with care-related problems through patient satisfaction surveys.
- ◇ Cases meeting blood transfusion criterion; i.e., single unit transfusions, signs/symptoms of reaction, etc.
- ◇ Over-read of selected radiology report.
- ◇ Selection of a set number of cases for each physician (i.e., every 10th) to ensure all physicians are incorporated into the peer review process.

The peer review process is also meant to include a review of the services provided by a nurse practitioner, physician assistant and clinical nurse specialist.

## UTILIZATION REVIEW

Utilization review is the term used for monitoring appropriateness of hospitalization for patients in a hospital. It is used to reduce unnecessary medical services. Utilization reviews the necessity, use, appropriateness, efficacy or efficiency of health-care services, procedures, providers or facilities. 42 CFR 489 contains the basic requirements for submittal and acceptance of a provider agreement under Medicare. Subpart B of this part specifies the basic commitments and limitations that the provider must agree to as part of an agreement to provide services. 42 CFR 489.20(e) states: "In case of a hospital or CAH that furnishes inpatient hospital services or inpatient CAH services for which payment may be made under Medicare, to maintain an agreement with a QIO for that organization to review the admissions, quality appropriateness and diagnostic information related to those inpatient services."

The federal general acute hospital regulations at 42 CFR 482.30 require the hospital to have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

The hospital UR plan should include a delineation of the responsibilities and authority for those involved in the performance of UR activities. It should also establish procedures for the review of the medical necessity of admissions, the appropriateness of the setting, the medical necessity of extended stays, and the medical necessity of professional services.

The regulation permits the hospital to have an agreement with a quality improvement organization (QIO) to perform utilization review. Most hospitals comply with the UR requirement by means of an agreement with the QIO. Since the beginning of the QIO program, the UR function delegated to a hospital has essentially been eliminated. The regulation at 42 CFR 489.230(e) requires a hospital to

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### ***Requirements for Hospital and Critical Access Hospital (CAH) Disclosures***

42 CFR 489.20(v) was added to the provider agreement requirements, mandating that all hospitals and CAHs provide written notice to all patients at the beginning of an inpatient stay or outpatient visit if there is no doctor of medicine or doctor of osteopathy present in the hospital 24 hours per day, seven days per week, in order to assist the patient in making an informed decision about his/her care, in accordance with 42 CFR 482.13(b)(2). The notice also must indicate how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition, as defined in 42 CFR 489.24(b) [the EMTALA definition], at a time when no physician is present in the hospital or CAH. The regulation provides the same clarification about when a hospital/CAH stay or outpatient visit “begins,” as in the regulation concerning physician-owned hospital disclosures.

In the case of a hospital that participates in Medicare with multiple campuses, satellites, remote and/or provider-based locations all covered under one CMS certification number, presence of a physician 24 hours per day, seven days per week in any portion of the hospital means that there is no requirement to make this disclosure. For example, if a hospital has three campuses, only two of which have a physician present 24/7, there is no requirement for the third campus to make a disclosure that there is no physician present 24/7 at that campus. Likewise, if a hospital’s main campus has a physician present 24/7, there is no requirement for a disclosure by any of its provider-based locations that do not have a physician at that location 24/7.

Enforcement of the mandatory disclosure requirements is linked to the Patients’ Rights Conditions of Participation (CoP) for hospitals and the Compliance with Federal, State, and Local Laws and Regulations Conditions of Participation (CoP) for CAHs. The Patient’s Rights CoP for hospitals at 42 CFR 482.13(b)(2) states that a patient has the right to make informed decisions regarding his or her care. The CoP at 42 CFR 485.608 requires that the CAH and its staff be in compliance with applicable federal, state, and local laws and regulations.

The compliance of hospitals and CAHs with the disclosure requirements is to be assessed when surveying hospitals for compliance with the Patients Rights CoP and CAHs for the Compliance with Federal, State, and Local Laws and Regulations CoP. The interpretive guidelines in the State Operations Manual (SOM) for the Patients’ Rights CoP for hospitals and the Compliance with Federal, State, and Local Laws and Regulations CoP for CAHs are being amended to reflect the regulatory requirements governing these mandatory disclosures.

For all hospitals and CAHs, surveyors are expected to determine whether a doctor of medicine or a doctor of osteopathy is on-site 24 hours/day, seven days/week. If a doctor of medicine or osteopathy is not on-site at a hospital or CAH at all times, surveyors must then verify that the hospital/CAH has appropriate policies and procedures in place to ensure that written notice of this is provided to all patients at the beginning of an inpatient stay or outpatient visit. The notice must also indicate how the hospital/CAH will meet the medical needs of a patient who develops an emergency medical condition when there is no doctor of medicine or osteopathy on site. Surveyors also may interview hospital/CAH staff to assess their knowledge and understanding of the notice requirements when a physician is not on site 24/7. If appropriate in terms of the scope of the survey underway at the facility, surveyors also may survey the hospital or CAH for its compliance with the applicable requirements concerning provision of emergency services. (See 42 CFR 482.55 and S&C-07-19 for hospitals and 42 CFR 485.618 for CAHs.)

More information on this can be found at:

[www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-16.pdf](http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-16.pdf).

Source:

CMS S&C letter 08-07



# ***HOSPITAL HAPPENINGS***

## ***NEW SURVEY AND CERTIFICATION LETTERS***

The Centers for Medicare and Medicaid Services (CMS) transmits memoranda, guidance, clarifications and instructions to state survey agencies and CMS regional offices through use of survey and certification (S&C) letters. Below is a list of the new S&C letters affecting hospitals since July 14, 2008. The S&C letters are available at [www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage](http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage).

- S&C 08-30 2008 Physician Fee Schedule Changes Affecting Survey & Certification.

On Nov. 27, 2007, CMS published revisions to payment policies under the Physician Fee Schedule. These changes affected certain CMS Conditions of Participation.

- S&C 08-34 Compliance With State Fire and Safety Code in Lieu of Life Safety Code.

CMS has adopted the 2000 edition of the National Fire Protection Association's (NFPA) Life Safety Code (LSC) as part of the Medicare health and safety standards for certified providers and suppliers.

- S&C 09-02 Approved of Deeming Authority of Det Norske Veritas Healthcare, Inc. for Hospitals.

CMS approved Det Norske Veritas (DNV) Healthcare, Inc. for recognition as a national accreditation program for hospitals seeking to participate in the Medicare program.

- S&C 09-03 Enforcement of Section 506, MMA, Acceptance of Medicare-like Rates.

Section 506 of the MMA requires hospitals and critical access hospitals to accept Medicare-like rates when providing care to individuals who are beneficiaries of Indian Health Service, Tribal health, and urban Indian health programs. 42 CFR 489.29 implements the statutory requirement.

- S&C 09-08 Accreditation and Its Impact on Various Survey and Certification Scenarios.

CMS has developed a comprehensive set of frequently asked questions and responses related to the impact of a provider/supplier's accreditation status on various survey and certification.

- S&C 09-09 Advance Copy — Organ Transplant Program State Operations Manual (SOM) and Survey Protocol.

Advance copy of changes to Chapters 2 and 3 of the SOM and the Survey Protocol, which will be included in Appendix X of the SOM.

- S&C 09-10 Standing Orders in Hospitals Revisions to S & C Memoranda.

Clarification of a portion of S&C 08-12 and S&C 08-18, issued on Feb. 8 and April 11, 2008, respectively, regarding use of standing orders in hospitals. The use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care or other patient safety advances.

- S&C 09-12 SOM Chapter 5 Update — Release of Person-Identifiable Data Related to Restraint/Seclusion Deaths.

S&C 08-23, issued May 30, 2008, updated Section 5140 of the SOM, concerning handling of hospital reports of deaths associated with the use of restraint or seclusion. Sections 5140.3 and 5140.4 are being revised further to streamline the process for disclosing restraint/seclusion death report data to protection and advocacy organizations (P and A's). New exhibits are added to facilitate the implementation of Data Use Agreements with P and A's.





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maintain an agreement with a QIO to review admission, quality, appropriateness and diagnostic information. In this case, there must be a signed and dated agreement.

With the recent change in the QIO's scope of work, the actual entity that performs this utilization review may be shifting.

## RECORD REVIEW FOR CAH PERIODIC EVALUATION REQUIREMENT



The federal CAH regulations at 42 CFR 485.641(a) (1) (ii) require the CAH to review a representative sample of both active and closed clinical records. The interpretive guidelines indicate that this review must be no less than 10 percent of both active and closed patient records.

For this regulation, the intent of the chart review is not to look at quality of care but to review the services furnished. For example, was there a service or a treatment not available to the patient and thus this service or treatment needed to be obtained from another provider or entity? Did the lack of services or treatments available or provided have an impact on the patient's length of stay or result in delay of treatment or diagnosis? The purpose is to aide in the determination of whether the utilization of services was appropriate, the established policies were followed, and any changes are needed. Think of this as more of a business review, rather than quality assurance.

*As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them.*

*~John Fitzgerald Kennedy*



## CONCLUSION

In summary, peer review is an integral aspect of your hospital's quality assurance/assessment program. Its main focus is the review of the QUALITY of the medical care provided to your patients. Utilization review is the monitoring of the appropriateness of hospitalization. The main focus of the record review for the CAH periodic evaluation is a business review. All of these reviews serve different purposes, all of which are very important in the functioning of the hospital and the service provided to the patients.

If you have any additional questions, please contact Bridget Weidner at [bweidner@nd.gov](mailto:bweidner@nd.gov).

## Resources:

State Operations Manual Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.

State Operations Manual Appendix W—Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs.

Title 42—Public Health Chapter IV—Centers for Medicare and Medicaid Services, Department of Health and Human Services Part 489—Provider Agreements and Supplier Approval

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